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ACC NEWS

President's Page: Concerns About Fragmentation of Adult Cardiology

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When I graduated from Johns Hopkins Medical School in 1960 internal medicine was considered a specialty, but subspecialties of internal medicine were just emerging. As I recall, there were *three* full-time members of the Division of Cardiology. When I was a fellow trainee in that division in 1965 to 1967, there were four full-time members, and when I left Johns Hopkins to take a position at the University of Florida in 1974, there were eight full-time faculty members in cardiology. Today, 15 years later in that same institution, there are 25 full-time cardiologists. As in my own cardiology division, many faculty members have developed subspecialty interests such as cardiac ultrasound, catheterization and angiography, coronary angioplasty, electrophysiology and nuclear cardiology. These subspecialty areas occurred naturally because the broad field of cardiology demanded it.

Departments of medicine over the years have had great concern about the fragmentation of the departments into specialty areas, the ultimate fear being that large specialty areas such as cardiology might eventually demand independence from internal medicine. So far as I can tell, this has not yet happened and, if I had to predict, it will not happen in the immediate future.

Growth of subspecialties in cardiology. Today, academic cardiology division chiefs are beginning to understand the concerns that department of medicine chairmen have expressed over the years. There are now so many subspecialty areas in cardiology that the general cardiologist has difficulty keeping up with the latest diagnostic and therapeutic recommendations of these subspecialists. Research in the cardiovascular subspecialty areas can be so sophisticated that the clinical cardiologist or the cardiologist working in another area has difficulty understanding the methods used. In recent years these subspecialists have tended to form subspecialty societies for exchange of scientific and clinical ideas relating to the area of subspecialized interest. Typical examples are the American Society of Echocardiography, the Society for Cardiac Angiography and Interventions, North American Society for Pacing and Electrophysiology, nuclear medical societies and more. The formation of these societies has been good for cardiology, but I am beginning to sense an undercurrent of separatism evolving.

Advantages of avoiding separatism. Just as the house of internal medicine has been concerned about fragmentation, as I see it, in 1989 the house of cardiology is equally concerned about fragmentation of adult clinical cardiology. I take the position, and I hope that I can convince others to agree, that it is in our best interest as clinical cardiovascular specialists to stay united under the large umbrella of clinical cardiology. There is a natural tendency for those sitting in judgment of subspecialty recommendations on clinical practice and reimbursement issues to think of our opinions as self-serving. If we stay united and develop consensus opinions and recommendations about the practice of our specialty and about cardiovascular health policy and reimbursement issues, we will have a stronger voice when and if others disagree with our positions.

As President of the American College of Cardiology I had the opportunity to attend the American College of Physicians (ACP) Council of Subspecialty Societies meeting during the April 1989 ACP annual meeting in San Francisco. It was obvious that the ACP has the same concerns and shares the same view, i.e., it is better to speak collectively rather than as splinter groups of subspecialties when dealing with the government or third-party payers and in developing practice guidelines for the care of our patients.

The issue of subspecialty examinations. In recent years, several subspecialty disciplines in cardiology have discussed and advocated the development of certification examinations for special competence. I have no problem with the issue of determining special competence in our subspecialties, but I am concerned that we may not be going about the task in an organized and systematic manner. Each subspecialty seems

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to want to develop its own examination, a goal that may be more divisive than it appears. In my view, for the reasons stated earlier, this is a time for cardiology to be united, not divided.

College statement on certification in adult cardiology. At the March 1989 Annual Scientific Session of the American College of Cardiology in Anaheim, the Executive Committee and the Board of Trustees of the College adopted the following statement relative to certification in adult cardiology:

> The College is concerned about the fragmentation of general cardiology into subspecialty interests but does not oppose the acknowledgement of special competence in qualified individuals.
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> If examinations for added qualifications in adult cardiology are to be administered, it is the official position of the American College of Cardiology that these should be administered by the American Board of Internal Medicine.
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> Moreover, the American College of Cardiology will strive to coordinate and facilitate the discussion of the appropriateness of these examinations and, as appropriate, to participate in the development of these examinations in cooperation with the American Board of Internal Medicine in cardiovascular subspecialty societies.

I am pleased that the College has made this statement, and I hope that our membership will be patient as we work through these complex issues.